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California HIV/AIDS Update

In This Issue:

California's HIV Partner Counseling and Referral Services Program

Catherine Baker, Drew Johnson, and Harold Rasmussen
Office of AIDS

The California Department of Health Services, Office of AIDS (OA) has established the HIV Partner Counseling and Referral Services (PCRS) Program. This is a comprehensive, statewide HIV prevention program that ensures that a "good faith" effort is made to provide HIV partner and spousal consultation services to HIV positive persons in California. The purpose of this article is to define PCRS, describe the background for the Program, and outline the Program's major activities.

Definition

PCRS encompasses many activities, including those called "partner management" and "partner notification."[1,2] HIV PCRS is generally described as the process whereby the HIV-infected individual or a health care provider notifies the HIV-infected individual's sex- and/or needle-sharing partner(s)* regarding possible exposure to HIV.

When performed by a health care provider, PCRS is always confidential, in that the name or other identifying information of the HIV-positive client is never divulged to the partner(s) of the HIV-positive client. PCRS services include:

- ✓ offering counseling to both the HIV-positive client and the sex- and/or needle-sharing partner(s);
- ✓ offering free HIV antibody testing to partner(s); and
- ✓ linking partner(s) to other appropriate services (e.g., treatment for HIV, STD, TB, or substance use).

Program Background

OA funds over 500 HIV counseling and testing (C&T) sites throughout the state. Approximately 2,500 newly identified HIV positive persons are served each year at these sites. Many of these persons have had several sex- and/or needle-sharing partners in the

* In this article, the term "needle-sharing" is intended to mean "needle-and/or syringe-sharing."

past who could have been unknowingly infected and may be exposing others to the virus, including pregnant women.

The mission of the PCRS Program is to provide HIV positive persons identified at these C&T sites with information, counseling and resources that will encourage them to notify their sex- and/or needle-sharing partners of the potential risk for HIV infection. This notification may occur either directly or through provider-assisted methods. The Program assures that notified persons are offered counseling and medical follow-up.

The main objectives of the PCRS Program are: a) the development of statewide guidelines for local programs; b) the notification of potentially exposed sex- and needle-sharing partners; c) the training of public health staff who are most likely to counsel HIV positive persons; and d) the establishment of HIV PCRS pilot projects.

Development of Statewide Guidelines

The OA has initiated a PCRS Guidelines Committee. This committee includes representatives from the federal Centers for Disease Control and Prevention (CDC); the Division of Communicable Disease Control of the California Department of Health Services; and the HIV prevention and sexually transmitted disease (STD) control offices of Los Angeles and San Francisco. The purpose of this committee is to update the California HIV PCRS written guidelines, last revised in 1988.

The committee examines issues such as essential PCRS program components, providing PCRS to anonymous test clients, prioritization of clients for PCRS, confidentiality and record keeping protocols, potential for domestic/family violence and/or sexual abuse and critical interview periods. OA will be developing a data collection system to measure program success and will be creating a system for sharing of information and disposition of cases among jurisdictions. A review panel of medical ethicists, public health attorneys, medical providers, and public health representatives will be convened to discuss non-consensual notification standards and guidelines as well.

In its work, the committee will maintain contact with the CDC, which is revising its national PCRS guidelines.

Methods of Notification

According to the current California PCRS guidelines[3], HIV positive clients should be informed that partners could be notified/counseled in at least three ways: client referral, provider-assisted referral, and provider-only referral. A fourth method, contract referral, has also been described in the literature.[1]

- ✓ Client Referral: Clients who choose to notify their partners directly can be "coached" by the HIV counselor to prepare for this process. This may be accomplished through role-playing, prioritization, scheduling, and follow-up consultations. This process can occur during the HIV C&T disclosure session, a separate PCRS visit, an Early Intervention Program (EIP) session with a case manager, or other follow up medical or counseling service.

- ✓ Provider-Assisted Referral: HIV prevention counselors may offer direct assistance to their clients by offering "dual counseling" services. These are services whereby partners are notified of their exposure by the index client in front of the HIV counselor, with the counselor taking on the role of facilitator. Because this option is potentially the most challenging for the counselor, it is recommended that only trained mental health professionals and/or veteran HIV counselors with PCRS expertise deliver such "dual counseling" services.

- ✓ Provider-Only Referral: This model had been used successfully for many years in communicable disease programs such as STD and tuberculosis control. HIV positive clients provide identifying and locating information for their partners and the public health representatives conduct the notifications and referrals while maintaining the anonymity of the original client. The CDC has developed standard forms for this purpose. OA will soon be providing training for public health counselors and other prevention providers to develop this interviewing skill (see next page).

- ✓ Contract Referral: This type of referral is considered to be a cross between client referral and provider referral. Contract referrals involve a time

frame (e.g., three days) during which the client will contact and refer the partners. If the client is unable to complete the task within the specified time, the PCRS provider then has the permission and information necessary to serve the partner. Negotiation skill and a relationship of trust are needed so the provider will have the identifying and locating information immediately available if the client fails to inform the partner before the time limit expires.

Non-Consensual Notification

In some circumstances HIV positive persons do not want partners notified. They may assume their partners already know of their risk or fear that negative consequences may occur if partners are informed. Fear of abandonment by significant others, loss of a place of residence or employment, even violence and abuse could drive HIV positive persons away from the discussion of partner referral. It is important that PCRS providers adequately assess the cause of the patient's refusal and provide the patient with appropriate support and counseling about the benefits to both the infected person and his or her partners. If a patient is unwilling to disclose the name(s) of his or her partners, the provider will have to counsel the infected person as if he or she is choosing the self-referral approach.

In some cases, the provider already knows of a partner at risk even though the infected patient has not identified that partner. California law permits physicians/surgeons and local health officers to contact potentially exposed sex- and needle-sharing partners of confirmed HIV positive persons without client authorization, provided certain conditions are met. California Health and Safety Code Section 121015 also exempts a physician/surgeon from civil or criminal liability in the confidential notification of specified third parties. This Code describes the following conditions, which must be met *in advance* of a disclosure:

1) the initial HIV positive test result (ELISA) must be followed up by an FDA approved confirmatory test (IFA or Western blot);

2) the notification must be made only for the purpose of diagnosis, care and treatment of the person(s) notified or to interrupt the chain of transmission;

3) the exposed partner is "reasonably believed" to be the spouse, sexual partner, and/or needle-sharing partner; and,

4) before a non-consensual notification can be attempted, the physician must:

- ✓ discuss the positive test result with the HIV positive patient;
- ✓ offer appropriate education and psychological counseling;
- ✓ attempt to obtain voluntary consent to notify from the index case; and
- ✓ inform the index case of his/her intent to notify the third party(ies).

In addition to meeting all of the above conditions, the law requires that physicians refer all notified third parties for appropriate care, counseling and follow up. The law also permits physicians/surgeons to disclose pertinent information to a local health officer so that the health officer, not the physician, conducts the notification. (In most counties, the health officer delegates this duty to disease intervention specialists housed within the STD control program and/or the HIV/AIDS program.)

Training Public Health Staff

The PCRS training is to be offered free of charge to HIV prevention providers, such as C&T staff, EIP staff, AIDS surveillance staff, or any other medical provider who is seeking skill building. The three-day course will be offered statewide and will be facilitated by experienced trainers working for the California Department of Health Services' STD/HIV Prevention Training Center in Berkeley.

The main course objective is to provide HIV prevention workers with skills and knowledge to effectively counsel HIV positive persons about their partners' referral needs. The course also introduces state data forms to be used to assess program efficacy. Many HIV counselors working in HIV C&T sites are not comfortable with the discussion of PCRS because the OA HIV counselor training program has not adequately prepared them for this role. With as many as 2,500 clients per year learning of their HIV positive status in OA-funded testing facilities, there exists a great need for intensive partner referral training of counselors. Once public health training needs are being met, the PCRS project may expand its training capacity to include a private medical practitioner training that will encourage PCRS consultations and referrals within private practice and local hospitals.

Pilot Projects

OA will be establishing five pilot projects in high incidence counties/regions to provide direct services to the local PCRS programs. Disease intervention staff will be assigned to each county/region to conduct PCRS interviews and follow-up of partners. Staff will transfer HIV positive clients from anonymous to confidential services, develop local referral linkages with public and private practitioners, and provide technical assistance to state funded HIV prevention programs. They will also identify "risk networks;" establish linkages between HIV, STD and EIP programs; assure consistency with state guidelines; and provide quality assurance.

Conclusion

The current possibilities for managing HIV disease are very encouraging. New medications have recently brought about significant improvement in the health status of many patients with advanced HIV disease. The available data suggest that the earlier such interventions are started, the greater the chances of a beneficial outcome.

PCRS services have the potential to identify exposed and infected persons early in the course of HIV disease. The possibility that sex- and/or needle-sharing partners could be prophylactically treated and counseled to prevent the further spread of HIV infections may serve as a basis for more widespread acceptance of such treatments. Greater commitment to the development of carefully targeted and properly managed HIV PCRS programs throughout California will also result. Other HIV prevention efforts continue to target individuals and groups at high risk. Nevertheless, efforts to increase the availability and use of PCRS may well prove worthwhile given the ability of PCRS to deliver HIV prevention services to individuals at maximum risk.

References

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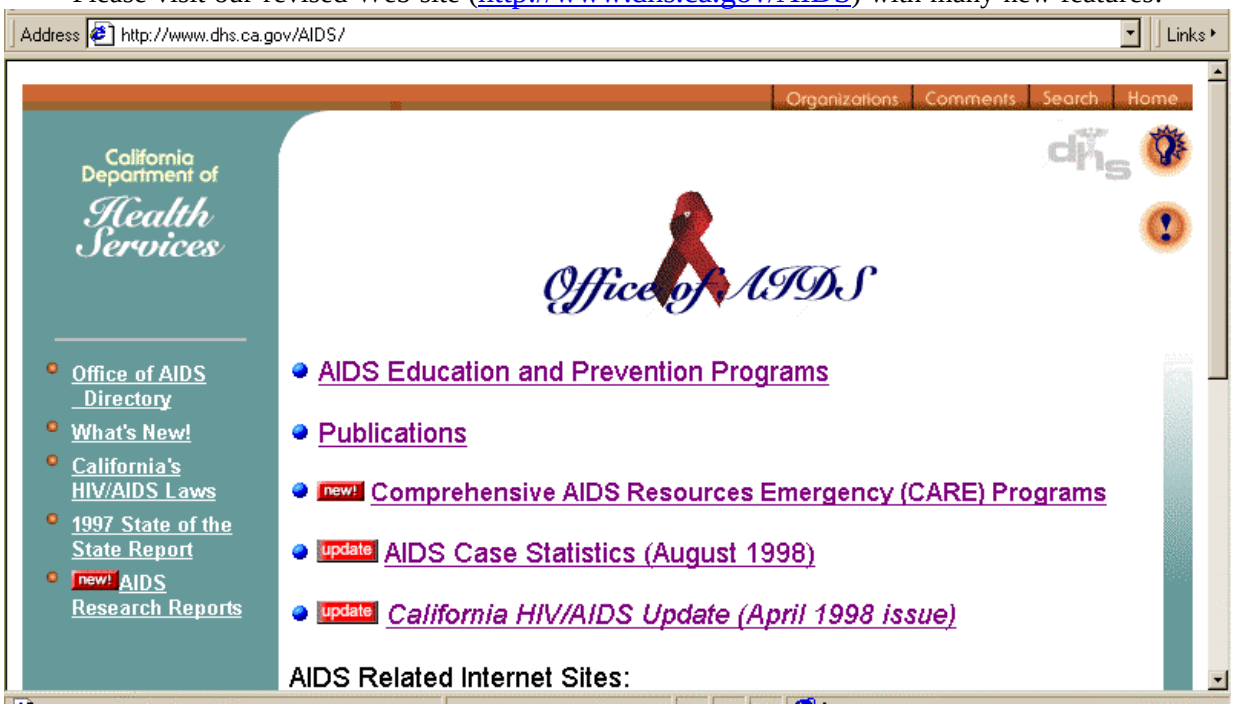
2. West GR, Stark KA. Partner notification for HIV prevention: a critical reexamination. AIDS Educ Prev 1997;9(Suppl B):68-78.

3. Chapter IV, HIV Counseling & Testing Services. In: HIV Counseling and Testing Guidelines, Policies and Recommendations. Sacramento: California Department of Health Services; 1997.

Please visit our revised Web site (http://www.dhs.ca.gov/AIDS) with many new features!



HIV Testing in California Blood Banks and Plasma Centers, and Transfusion-Related AIDS Cases in California

Bob Poindexter and Richard Sun
Office of AIDS

California Health and Safety Code Section 120980(j) and Title 17 of the California Code of Regulations, Section 1320(g), require California blood banks and plasma centers to report statistical summaries of their HIV test results to the California Department of Health Services. This article describes the methods and results of these statistical summaries through December 1997. In addition, this article summarizes the data on transfusion-related AIDS cases in California received by the California Department of Health Services through December 1997.

Methods: Blood Bank and Plasma Center Reports

After a blood test for HIV was licensed in 1985, California Health and Safety Code, Section 1603.1, was amended to require blood or blood components to "have been tested and found nonreactive for HIV." Any HIV positive units are discarded.

Blood bank and plasma centers report their HIV test results to the Office of AIDS on a standard form. Data collection for blood banks began in the second half of 1987 and for plasma centers in the first half of 1990. Before February 1997, blood banks and plasma centers submitted reports on a quarterly basis; subsequently, a six-month reporting frequency was adopted. Information gathered includes the number of donations made for the previous six-month period and the number of confirmed HIV-1 cases. Office of AIDS staff use Microsoft Excel and Access software to input and analyze the data, and to produce a semi-annual report for interested parties.

Methods: Transfusion-Related AIDS

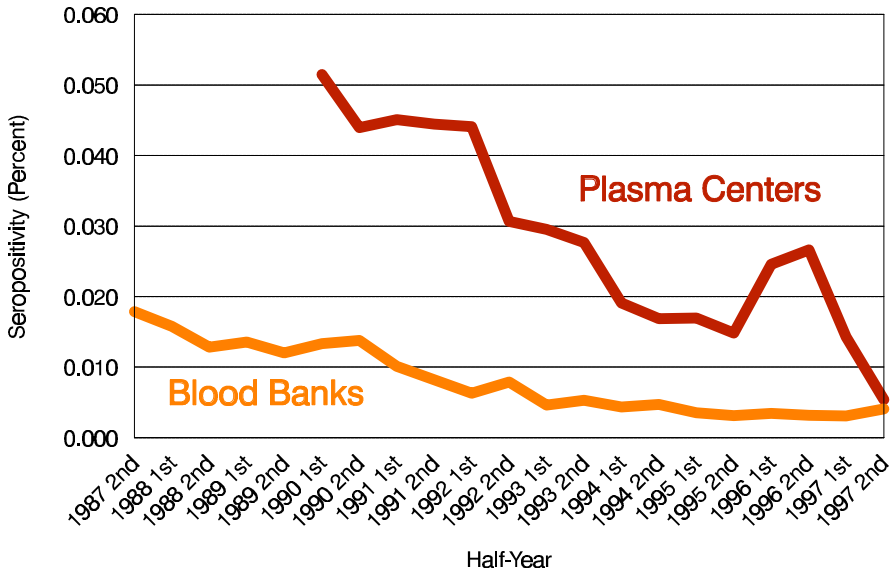
In California, local health departments collect information on diagnosed AIDS cases from physicians, hospitals, and other sources. Data on each case are transmitted to the Office of AIDS. AIDS cases that may have been caused by HIV transmitted via transfusion are investigated using a protocol developed by the Centers for Disease Control and Prevention.[1] We analyzed the date of transfusion, the date of diagnosis, and the date of report of transfusion-related California AIDS cases reported through December 31, 1997.

Results

Between the second half of 1987 and the second half of 1997, 11,772,352 units of blood were tested, a mean of 560,588 per half-year period. Between the first half of 1990 and the second half of 1997, 5,400,992 units of plasma were tested, a mean of 337,562 per half-year period. The seropositivity of HIV has declined in both plasma centers and in blood banks, but the seropositivity in the former is higher than in the latter (Figure 1). For blood banks, the overall seropositivity was 0.009%, declining from 0.018% in the second half of 1987 to 0.004% in the second half of 1997. For plasma centers, the overall seropositivity was 0.028%, declining from 0.052% in the first half of 1990 to 0.005% in the second half of 1997.

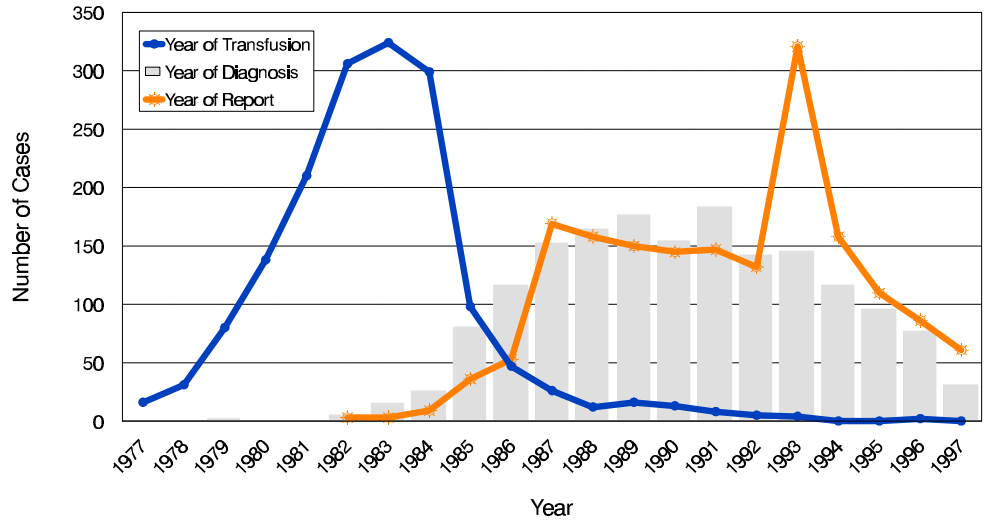
When transfusion-related AIDS cases were analyzed by year of transfusion, there was a sharp increase between 1976 and 1983 (Figure 2). After the mandatory blood screening law went into effect in 1985, the number of cases of AIDS related to blood transfusions immediately decreased. The mean number of months between transfusion and AIDS diagnosis was 91.3, and between transfusion and AIDS report was 102.5. The high number of transfusion-related cases reported in 1993 was due to the change in the case definition of AIDS.[2]

Figure 1. HIV Seropositivity by Half-Year of Report -- California Blood Banks and Plasma Centers, July 1987 to December 1997



Source: Office of AIDS, California Department of Health Services. Data reported as of June 1998.

Figure 2. California AIDS Cases Acquired Through Transfusion, by Year of Transfusion, Year of Diagnosis, and Year of Report -- 1977-1997



Source: California Department of Health Services, Office of AIDS.
Data are for AIDS cases diagnosed through December 1997 and reported as of June 1998.
Excludes 56 AIDS cases who received transfusions outside the United States.

Discussion

The U.S. General Accounting Office (GAO) in 1997 concluded that the risks of transfusion-related diseases, including HIV, are "very small."[3] For HIV, the GAO estimated that the risk is 1 in every 450,000 units, which is consistent with two previous studies.[4,5] Most of the remaining risk for transfusion-associated HIV is a result of "window period" donations, which produce blood that can transmit HIV but that has no detectable antibodies to HIV. The "window period" between HIV infection and the detection of antibodies is currently estimated to be 22-25 days.[3]

Some people have argued that the blood supply needs greater protection from HIV; however, a recent paper states that "because the risk for viral transmission by allogenic transfusion is already low, additional measures will have limited yield and poor cost-effectiveness."[6] The authors acknowledge that factors other than cost-effectiveness may influence public policy decisions. The continued compilation of data on HIV tests from blood banks and plasma centers, and on transfusion-related AIDS cases, will help inform public debate to assure that "the blood supply will remain relatively safe."[7]

Acknowledgment

The authors thank Augustine Detres and Sharon Ito for assistance with the transfusion-related AIDS data.

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2. CDC. 1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults. MMWR 1992;41(RR-7).

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Accessing Information From the 12th World AIDS Conference on the World Wide Web

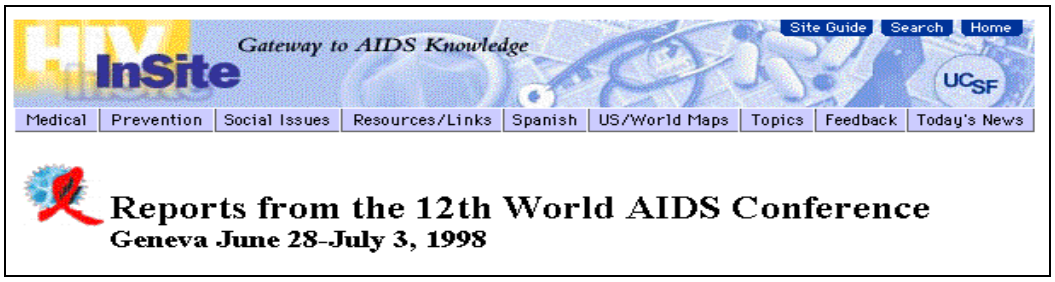
Richard Sun
Office of AIDS

The 12th World AIDS Conference was held in Geneva, Switzerland, from June 28 through July 3 of this year. Its theme was "Bridging the Gap." Information from the conference can be found on many sites on the World Wide Web, including the following sites whose Uniform Resource Locators are given in parentheses.

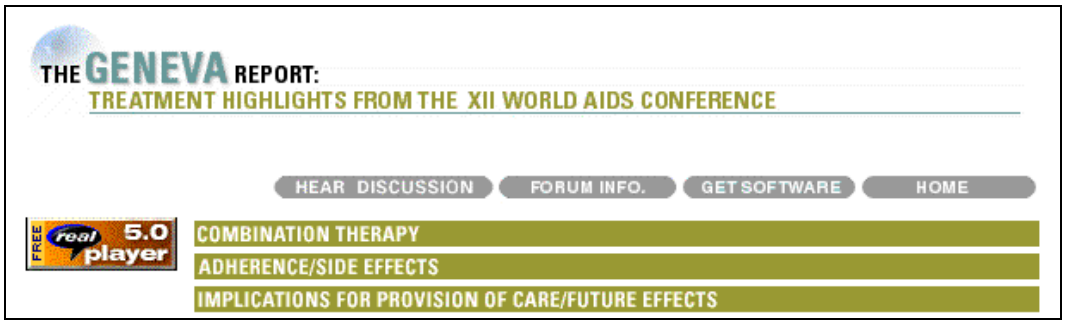
1. Official Conference Site (http://www.aids98.ch): Among other items, this includes *The Bridge* (the on-site daily newspaper) and summaries of each day's presentations by track.

2. Official Webcast (http://webcast.aids98.org).

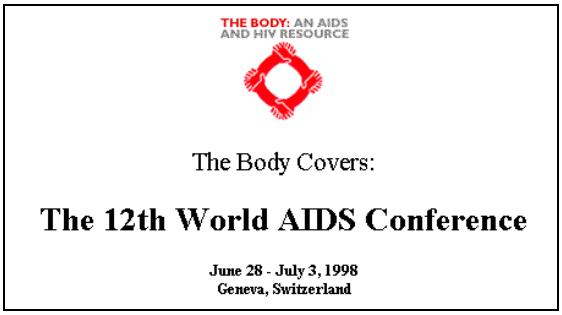
3. HIV InSite (http://hivinsite.ucsf.edu/img/soc/geneva98.html): From the University of California at San Francisco. Includes both text and audio summaries of the conference.



4. The Geneva Report: Treatment Highlights (http://www.hopkins-aids.edu/geneva/archive.html): A site from Johns Hopkins University AIDS Service.



5. The Body (http://www.thebody.com/confs/worldaids698/worldaids698.html): Contains conference summaries, news, events, reports, and related articles.



In addition, these five sites have links to other sites with information about the conference.

Note: This list of Web sites is for information only. Inclusion in the list does not imply endorsement by the California Department of Health Services.

Table 1. **AIDS cases by age group, exposure category, and gender reported Ju1y 1, 1996 through June 30, 1997 and July 1, 1997 through June 30, 1998; and cumulative totals by age group through June 30, 1998 in California.**

	Male				Female				Totals					
Adult/adolescent Exposure Category	Jul. 1996-Jun. 1997 No.	%	Jul. 1997-Jun. 1998 No.	%	Jul. 1996-Jun. 1997 No.	%	Jul. 1997-Jun. 1998 No.	%	Jul. 1996-Jun. 1997 No.	%	Jul. 1997-Jun. 1998 No.	%	Cumulative Total No.	%
Homosexual/bisexual	5,055	73%	3,764	67%	-	-	-	-	5,055	65%	3,764	60%	76,766	72%
IDU (heterosexual)	706	10%	630	11%	288	36%	217	32%	994	13%	847	13%	10,614	10%
Homosexual/bisexual IDU	542	8%	398	7%	-	-	-	-	542	7%	398	6%	9,230	9%
Lesbian/bisexual IDU	-	-	-	-	14	2%	9	1%	6	-	9	-	121	-
Coagulation Disorders	22	-	24	-	-	-	1	-	22	-	25	-	533	-
Heterosexual	157	2%	147	3%	376	47%	284	42%	533	7%	431	7%	4,309	4%
Blood transfusion	32	-	31	1%	30	4%	22	3%	62	1%	53	1%	1,564	1%
Other/undetermined	424	6%	634	11%	85	11%	147	22%	517	7%	781	12%	3,711	3%
Subtotal	6,938	100%	5,628	100%	793	100%	680	100%	7,731	100%	6,308	100%	106,848	100%
Pediatric (< 13 years old) Exposure Category	Jul. 1996-Jun. 1997 No.	%	Jul. 1997-Jun. 1998 No.	%	Jul. 1996-Jun. 1997 No.	%	Jul. 1997-Jun. 1998 No.	%	Jul. 1996-Jun. 1997 No.	%	Jul. 1997-Jun. 1998 No.	%	Cumulative Total No.	%
Coagulation Disorders	1	6%	-	-	-	-	-	-	-	-	-	-	29	5%
Blood transfusion	-	-	-	-	1	7%	-	-	1	3%	-	-	111	20%
Mother at risk: --IDU	3	17%	4	29%	1	7%	1	14%	4	13%	5	24%	149	26%
--Sex with IDU	2	11%	2	14%	2	14%	1	14%	4	13%	3	14%	80	14%
--Sex w/bisexual male	1	6%	-	-	1	7%	-	-	2	6%	-	-	26	5%
--Sex w/HIV infected	2	11%	2	14%	1	7%	2	29%	8	25%	4	19%	67	12%
--Blood transfusion	-	-	3	21%	-	-	-	-	1	3%	3	14%	22	4%
--HIV infected	9	50%	2	14%	6	43%	3	43%	11	34%	5	24%	75	13%
Other/undetermined	-	-	1	7%	2	14%	-	-	1	3%	1	5%	8	1%
Subtotal	18	100%	14	100%	14	100%	7	100%	32	100%	21	100%	567	100%
TOTAL		6,956		5,642		807		687		7,763		6,329		107,415

Table 2. **AIDS cases by age group, exposure category, and race/ethnicity reported through June 30, 1998 in California.**

Adult/adolescent Exposure Category	White		Black		Hispanic		Asian/ Pacific Is.		Native American		Not Specified		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Homosexual/bisexual	52,626	79%	8,877	51%	13,290	66%	1,600	74%	254	57%	119	75%	76,766	72%
IDU (heterosexual)	3,930	6%	4,279	24%	2,109	11%	94	4%	66	15%	15	9%	10,493	10%
Homosexual/bisexual IDU	5,961	9%	1,712	10%	1,387	7%	78	4%	86	19%	6	4%	9,230	9%
Lesbian/bisexual IDU	53	-	42	-	21	-	1	-	4	1%	-	-	121	-
Coagulation Disorders	362	1%	42	-	100	-	24	1%	1	-	4	3%	533	-
Heterosexual	1,563	2%	1,346	8%	1,242	6%	138	6%	18	4%	2	1%	4,309	4%
Blood transfusion	911	1%	174	1%	363	2%	109	5%	3	1%	4	3%	1,564	1%
Other/undetermined	1,061	2%	1,086	6%	1,548	8%	116	5%	13	3%	8	5%	3,832	4%
Subtotal	66,467	100%	17,558	100%	20,060	100%	2,160	100%	445	100%	158	100%	106,848	100%
Pediatric (< 13 years old) Exposure Category	**White**		**Black**		**Hispanic**		**Asian/ Pacific Is.**		**Native American**		**Not Specified**		**TOTAL**	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Coagulation Disorders	15	9%	1	1%	11	5%	2	13%	-	-	-	-	29	5%
Blood transfusion	42	26%	23	13%	39	19%	7	47%	-	-	-	-	111	20%
Mother at risk:														
--IDU	50	31%	69	39%	26	12%	-	-	4	80%	-	-	149	26%
--Sex with IDU	18	11%	21	12%	39	19%	1	7%	1	20%	-	-	80	14%
--Sex w/bisexual male	8	5%	4	2%	13	6%	1	7%	-	-	-	-	26	5%
--Sex w/HIV infected	9	6%	13	7%	41	20%	3	20%	-	-	1	100%	67	12%
--Blood transfusion	7	4%	3	2%	12	6%	-	-	-	-	-	-	22	4%
--HIV infected	11	7%	40	23%	23	11%	1	7%	-	-	-	-	75	13%
Other/undetermined	-	-	2	1%	6	3%	-	-	-	-	-	-	8	1%
Subtotal	160	100%	176	100%	210	100%	15	100%	5	100%	1	100%	567	100%
TOTAL		**66,627**		**17,734**		**20,270**		**2,175**		**450**		**159**		**107,415**

Table 3. **Adult/adolescent AIDS cases by gender, exposure category, and race/ethnicity, reported through June 30, 1998 in California.**

Male Exposure Category	White		Black		Hispanic		Asian/ Pacific Is.		Native American		Not Specified		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Homosexual/bisexual	52,626	83%	8,877	59%	13,290	72%	1,600	82%	254	64%	119	78%	76,766	77%
IDU (heterosexual)	2,909	5%	3,069	20%	1,742	9%	64	3%	42	11%	10	7%	7,836	8%
Homosexual/bisexual IDU	5,961	9%	1,712	11%	1,387	8%	78	4%	86	22%	6	4%	9,230	9%
Coagulation Disorders	348	1%	40	-	98	1%	24	1%	1	-	4	3%	515	1%
Heterosexual	66,467	1%	412	3%	388	2%	61	3%	5	1%	2	1%	1,300	1%
Blood transfusion	585	1%	83	1%	172	1%	29	1%	2	1%	3	2%	874	1%
Other/undetermined	888	1%	827	6%	1,341	7%	93	5%	9	2%	8	5%	3,166	3%
Subtotal	63,749	100%	15,020	100%	18,418	100%	1,949	100%	399	100%	152	100%	99,687	100%
Female Exposure Category	White		Black		Hispanic		Asian/ Pacific Is.		Native American		Not Specified		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
IDU	1,074	40%	1,252	49%	388	24%	31	15%	28	61%	5	83%	2,778	39%
Lesbian/bisexual IDU	2	-	-	-	-	-	-	-	-	-	-	-	2	-
Coagulation Disorders	14	1%	2	-	2	-	109	52%	13	28%	-	-	140	2%
Heterosexual	1,131	42%	934	37%	854	52%	48	23%	1	2%	1	17%	2,969	41%
Blood transfusion	326	12%	91	4%	191	12%	22	10%	4	9%	-	-	634	9%
Other/undetermined	171	6%	259	10%	207	13%	1	-	-	-	-	-	638	9%
Subtotal	2,718	100%	2,538	100%	1,642	100%	211	100%	46	100%	6	100%	7,161	100%
TOTAL		66,467		17,558		20,060		2,160		445		158		106,848

Table 4. **AIDS cases in adolescents and adults under age 25, by exposure category reported Ju1y 1, 1996 through June 30, 1997 and July 1, 1997 through June 30, 1998; and cumulative totals by age group through June 30, 1998 in California.**

	13-19 years old						20-24 years old					
Exposure Category	**Jul. 1996-Jun. 1997**		**Jul. 1997-Jun. 1998**		**Cumulative Total**		**Jul. 1996-Jun. 1997**		**Jul. 1997-Jun. 1998**		**Cumulative Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Homosexual/bisexual	11	41%	8	27%	96	31%	130	60%	95	56%	1,902	61%
IDU (heterosexual)	1	4%	4	13%	15	5%	11	5%	8	5%	361	12%
Homosexual/bisexual IDU	-	-	3	10%	12	4%	23	11%	18	11%	304	10%
Lesbian/bisexual IDU	-	-	-	-	-	-	-	-	-	-	5	-
Coagulation Disorders	4	15%	2	7%	76	25%	2	1%	3	2%	65	2%
Heterosexual	2	7%	1	3%	40	13%	27	13%	19	11%	281	9%
Blood transfusion	6	22%	3	10%	44	14%	2	1%	-	-	37	1%
Other/undetermined	3	11%	9	30%	25	8%	20	9%	27	16%	157	5%
TOTAL	**27**	**100%**	**30**	**100%**	**308**	**100%**	**215**	**100%**	**170**	**100%**	**3,112**	**100%**

Table 5. AIDS cases by gender, age at diagnosis, and race/ethnicity, reported through June 30, 1998 in California.

Male Age at Diagnosis--Years	White No.	%	Black No.	%	Hispanic No.	%	Asian/ Pacific Is. No.	%	Native American No.	%	Not Specified No.	%	TOTAL No.	%
0-4	47	-	66	-	71	-	4	-	2	-	-	-	190	-
5-12	38	-	29	-	39	-	4	-	-	-	-	-	110	-
13-19	77	-	35	-	106	1%	9	-	2	-	-	-	229	-
20-24	1,262	2%	438	3%	901	5%	63	3%	15	4%	5	3%	2,684	3%
25-29	7,007	11%	1,956	13%	3,410	18%	251	13%	75	19%	21	14%	12,720	13%
30-34	14,100	22%	3,431	23%	4,741	26%	422	22%	110	27%	30	20%	22,834	23%
35-39	14,668	23%	3,459	23%	3,856	21%	434	22%	95	24%	36	24%	22,548	23%
40-44	11,286	18%	2,584	17%	2,501	13%	359	18%	52	13%	26	17%	16,808	17%
45-49	7,135	11%	1,514	10%	1,323	7%	206	11%	25	6%	14	9%	10,217	10%
50-54	3,959	6%	812	5%	747	4%	88	4%	10	2%	7	5%	5,623	6%
55-59	2,172	3%	423	3%	434	2%	61	3%	9	2%	8	5%	3,107	3%
60-64	1,175	2%	216	1%	229	1%	28	1%	3	1%	2	1%	1,653	2%
65 or older	908	1%	152	1%	170	1%	28	1%	3	1%	3	2%	1,264	1%
Subtotal	63,834	100%	15,115	100%	18,528	100%	1,957	100%	401	100%	152	100%	99,987	100%
Female Age at Diagnosis--Years	**White No.**	**%**	**Black No.**	**%**	**Hispanic No.**	**%**	**Asian/ Pacific Is. No.**	**%**	**Native American No.**	**%**	**Not Specified No.**	**%**	**TOTAL No.**	**%**
0-4	50	2%	65	2%	79	5%	4	2%	3	6%	1	14%	202	3%
5-12	25	1%	16	1%	21	1%	3	1%	-	-	-	-	65	1%
13-19	23	1%	23	1%	29	2%	4	2%	-	-	-	-	79	1%
20-24	138	5%	128	5%	147	8%	7	3%	3	6%	-	-	423	6%
25-29	401	14%	342	13%	317	18%	33	15%	8	16%	-	-	1,101	15%
30-34	587	21%	518	20%	343	20%	28	13%	12	24%	2	29%	1,490	20%
35-39	496	18%	579	22%	297	17%	45	21%	8	16%	1	14%	1,426	19%
40-44	387	14%	436	17%	200	11%	25	11%	6	12%	1	14%	1,055	14%
45-49	250	9%	258	10%	109	6%	27	12%	3	6%	1	14%	648	9%
50-54	132	5%	108	4%	74	4%	13	6%	4	8%	-	-	331	4%
55-59	76	3%	73	3%	58	3%	12	6%	1	2%	-	-	220	3%
60-64	69	2%	36	1%	37	2%	6	3%	-	-	-	-	148	2%
65 or older	159	6%	37	1%	31	2%	11	5%	1	2%	1	14%	240	3%
Subtotal	2,793	100%	2,619	100%	1,742	100%	218	100%	49	100%	7	100%	7,428	100%
TOTAL	**66,627**		**17,734**		**20,270**		**2,175**		**450**		**159**		**107,415**	

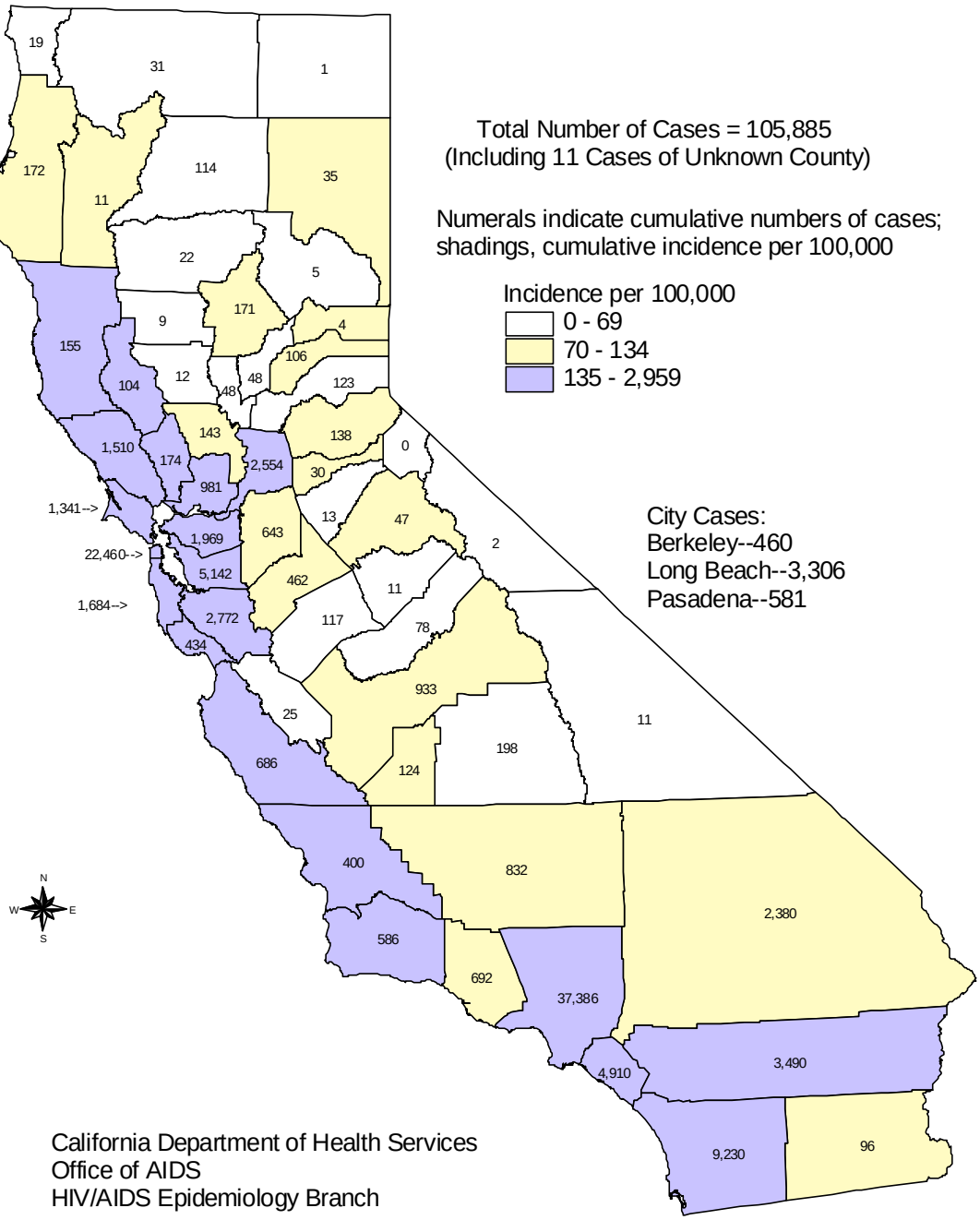
Table 6. AIDS cases, deaths, and case-fatality rates by half-year of diagnosis through June 30, 1998 in California.

Half-Year of Diagnosis	Number of Cases	Number of Deaths	Case Fatality Rate
Before 1983	305	290	95%
1983 Jan-June	296	286	97%
July-Dec	413	395	96%
1984 Jan-June	594	575	97%
July-Dec	812	780	96%
1985 Jan-June	1,161	1,120	96%
July-Dec	1,422	1,368	96%
1986 Jan-June	1,834	1,772	97%
July-Dec	2,231	2,132	96%
1987 Jan-June	2,760	2,639	96%
July-Dec	2,896	2,723	94%
1988 Jan-June	3,266	3,057	94%
July-Dec	3,404	3,119	92%
1989 Jan-June	4,025	3,616	90%
July-Dec	3,994	3,537	89%
1990 Jan-June	4,520	3,888	86%
July-Dec	4,447	3,775	85%
1991 Jan-June	5,283	4,306	82%
July-Dec	6,045	4,738	78%
1992 Jan-June	6,455	4,644	72%
July-Dec	6,383	4,278	67%
1993 Jan-June	6,317	3,754	59%
July-Dec	5,595	2,861	51%
1994 Jan-June	5,496	2,363	43%
July-Dec	4,785	1,678	35%
1995 Jan-June	4,994	1,300	26%
July-Dec	4,271	888	21%
1996 Jan-June	3,999	649	16%
July-Dec	3,073	389	13%
1997 Jan-June	2,800	278	10%
July-Dec	2,217	205	9%
1998 Jan-June	1,321	90	7%
TOTAL	**107,414**	**67,493**	**63%**

Table 7. AIDS Cases and Cumulative Incidence 1981 though June 30, 1998 in California.

COUNTY	AIDS Cases	Deaths	Mortality Rate	Incidence per 100,000	COUNTY	AIDS Cases	Deaths	Mortality Rate	Incidence per 100,000
Alameda	5,246	3,294	62.8%	376.57	**Orange**	4,999	2,789	55.8%	184.28
Berkeley	490	329	67.1%	467.11	**Placer**	126	68	54.0%	57.68
Alpine	-	-	-	-	**Plumas**	6	3	50.0%	27.49
Amador	32	17	53.1%	96.36	**Riverside**	3,597	1,861	51.7%	231.84
Butte	174	115	66.1%	85.37	**Sacramento**	2,573	1,632	63.4%	211.59
Calaveras	13	8	61.5%	29.70	**San Benito**	26	11	42.3%	58.63
Colusa	12	11	91.7%	62.38	**San Bernardino**	2,437	1,386	56.9%	136.95
Contra Costa	1,993	1,283	64.4%	219.11	**San Diego**	9,373	5,545	59.2%	343.84
Del Norte	19	10	52.6%	61.57	**San Francisco**	22,732	15,733	69.2%	2,995.09
El Dorado	137	88	64.2%	87.01	**San Joaquin**	656	404	61.6%	116.82
Fresno	932	591	63.4%	112.61	**San Luis Obispo**	405	192	47.4%	175.12
Glenn	9	6	66.7%	31.57	**San Mateo**	1,701	1,073	63.1%	239.24
Humboldt	171	103	60.2%	129.92	**Santa Barbara**	591	418	70.7%	148.52
Imperial	98	49	50.0%	73.15	**Santa Clara**	2,821	1,684	59.7%	173.08
Inyo	11	7	63.6%	56.38	**Santa Cruz**	442	270	61.1%	183.43
Kern	855	411	48.1%	125.79	**Shasta**	117	86	73.5%	65.82
Kings	125	56	44.8%	110.66	**Sierra**	4	4	100.0%	119.40
Lake	107	57	53.3%	174.27	**Siskiyou**	32	16	50.0%	68.14
Lassen	35	13	37.1%	130.33	**Solano**	993	552	55.6%	239.10
Los Angeles	37,880	24,098	63.6%	393.09	**Sonoma**	1,529	967	63.2%	347.42
Long Beach	3,353	2,086	62.2%	765.87	**Stanislaus**	467	278	59.5%	103.12
Pasadena	594	378	63.6%	441.96	**Sutter**	49	28	57.1%	61.69
Madera	77	43	55.8%	68.29	**Tehama**	22	11	50.0%	37.35
Marin	1,343	719	53.5%	556.41	**Trinity**	11	8	72.7%	77.64
Mariposa	11	3	27.3%	61.81	**Tulare**	208	148	71.2%	54.87
Mendocino	155	106	68.4%	170.82	**Tuolumne**	49	31	63.3%	87.44
Merced	118	70	59.3%	55.03	**Ventura**	708	445	62.9%	96.13
Modoc	1	1	100.0%	9.23	**Yolo**	143	91	63.6%	90.09
Mono	2	1	50.0%	18.48	**Yuba**	49	29	59.2%	70.23
Monterey	693	396	57.1%	182.14	**Unknown**	13	5	38.5%	
Napa	177	109	61.6%	146.81					
Nevada	110	60	54.5%	114.22	**TOTAL**	**107,415**	**67,493**	**62.8%**	**319.33**

Cumulative AIDS Cases in California by County, as of March 31, 1998



Total Number of Cases = 105,885
(Including 11 Cases of Unknown County)

Numerals indicate cumulative numbers of cases; shadings, cumulative incidence per 100,000

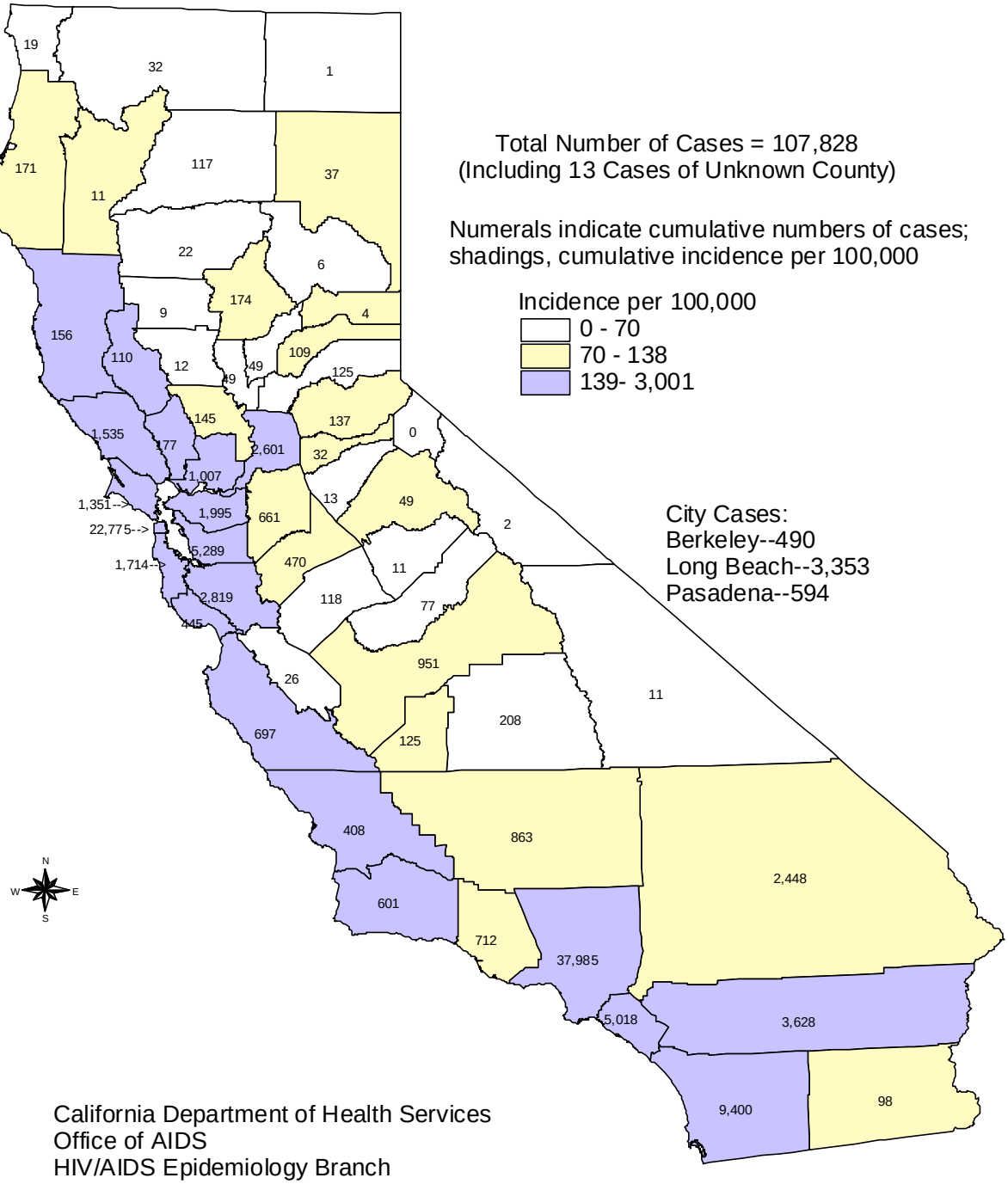
Incidence per 100,000
- 0 - 69
- 70 - 134
- 135 - 2,959

City Cases:
Berkeley--460
Long Beach--3,306
Pasadena--581

California Department of Health Services
Office of AIDS
HIV/AIDS Epidemiology Branch

Note: Map omitted from April issue

Cumulative AIDS Cases in California by County, as of July 31, 1998



Total Number of Cases = 107,828
(Including 13 Cases of Unknown County)

Numerals indicate cumulative numbers of cases; shadings, cumulative incidence per 100,000

Incidence per 100,000
- 0 - 70
- 70 - 138
- 139- 3,001

City Cases:
Berkeley--490
Long Beach--3,353
Pasadena--594

California Department of Health Services
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MEETINGS/ANNOUNCEMENTS

November 15-19, 1998 American Public Health Association Annual Meeting, Washington, DC. Topics range from AIDS to mental health, and from maternal and child health to social work. Contact Anna Keller at: anna.keller@apha.org, or (202) 789-5670. Web: www.apha.org

December 1, 1998 marks the eleventh World AIDS Day. The theme for the 11th annual World AIDS Day is "BE A FORCE FOR CHANGE: World AIDS Campaign with Young People". The Theme reflects the fact that worldwide five young people are infected with HIV every minute, making AIDS and HIV a very real part of everyday life for young people. Contact: Web: www.avert.org

March 12-14, 1999 'HIV Prevention in Rural Communities: Sharing Successful Programs and Building Strategies", Indiana University/Purdue University, Indianapolis. (800) 566-8644, or (812) 855-1718, FAX: (812) 855-3717, e-mail: aids@indiana.edu, Web: www.indiana.edu/ ~ aids

July 15 - 18, 1999 "AIDS Impact 1999" in Ottawa, Canada, focuses on the inter-connected biological, psychological and social aspects of HIV. The conference is an excellent opportunity for people living with HIV, researchers, health care practitioners and others to explore changing trends in the HIV epidemic throughout the world. Contact: Dr. John Service, Executive Director, Canadian Psychological Association. Web: http://www.cpa.ca.

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Department of Health Services
Office of AIDS
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 445-0553
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Editor: Grace L. Pace **Circulation Manager:** James Creeger

Technical Advisors: Robert Benjamin, MD, MPH, Alameda County
Michele M. Ginsberg, MD, San Diego County
Peter Kerndt, MD, MPH, Los Angeles County

Departmental Advisors: Vanessa Baird, Acting Chief, Office of AIDS
Richard Sun, MD, MPH, Chief, HIV/AIDS Epidemiology Branch
Steve Waterman, MD, Chief, Division of Communicable Disease Control

Department of Health Services
Office of AIDS
P. O. Box 942732
Sacramento, CA 94234-7320